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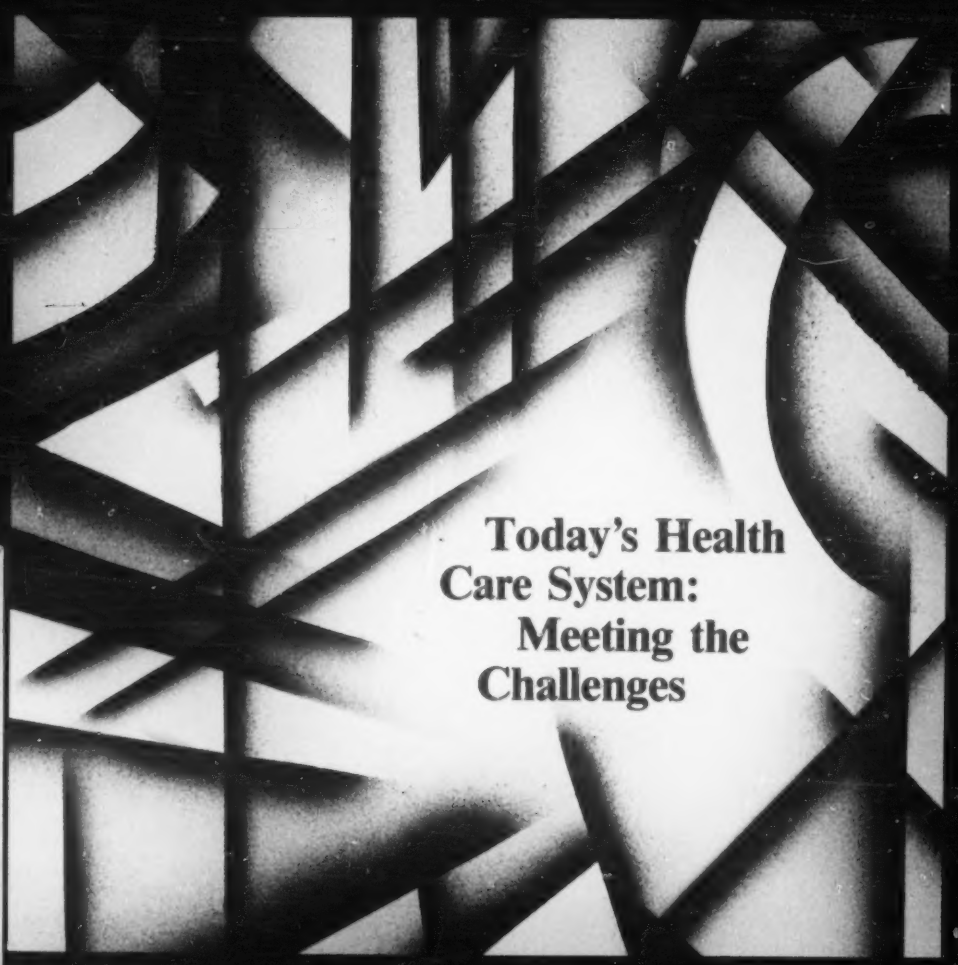

Today's Health Care System: Meeting the Challenges

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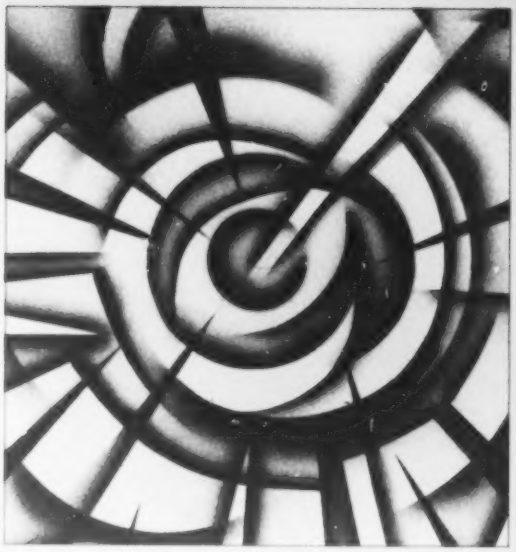

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Analysis of the Market Driven Nursing Shortage

Sr. Rosemary Donley and Sr. Mary Jean Flaherty

Donley and Flaherty look anew at the nursing shortage; they explain why the supply-side orientation cannot explain or resolve the problem. The mere increase in our numbers is not a solution in today's complex care environment. The authors explain the market-driven shortage and the changes in the work environment essential for ameliorating the shortage.

In December 1988 the Davis Commission on Nursing convened by Secretary Bowen to study the nursing shortage released its final report (Secretary's Commission on Nursing, 1988a). Other experts, from Goldmark (Winslow, 1923) to the Institute of Medicine Panel (1983), were dutifully convened, diligently employed, and were responsive in completing their work. However, their reports became part of the chronology of nursing studies—historical footnotes about a troubled profession. Old hands wonder whether the work of the Davis Commission will fare any better. Mindful of this history, the authors discuss the demand-driven elements of the shortage of the 1980s and examine the Commission's finding that conditions in the workplace are a factor in the nursing shortage.

Most students of nursing's labor market have emphasized the importance of the supply and demand equation. The Surgeon General's Report, which gave birth to the first generation of nurse training acts, saw a mandate for federal support of nurse training in the predictions of a changed health care system (National League for Nursing, 1963). As late as 1983, when the Institute of Medicine reported no shortage of bedside nurses, fluctuations in the nursing labor force were still being addressed within a supply side framework that emphasized recruiting and retaining nursing students and helping young graduates adjust in the workplace. In the present shortage, public and private efforts continue to address recruitment and retention. Recruitment initiatives have been aimed at typical nursing students: high school graduates. Men, minorities, and second careerists have been mentioned by foundations or the federal government as persons worthy of special attention. However, these groups have never been identified as mainstream candidates by faculties of nursing.

Failure to create places for new learners in an environment of declining 18-year-olds has contributed to enrollment problems in schools of nursing—what Green (1987) labels as "the problem in the nursing pipeline." Efforts to keep students in school by using loans, remedial programs, and flexible curriculums have become normative in traditional retention activities. While retention of all students requires effort, it is a truism that recruiting and retaining nontraditional students requires substantial and creative investment of human and financial resources. Successful retention programs seem to be influenced by steady financial support. They are hindered by stop-and-go federal, state, and private initiatives.

The Division of Nursing has played a major role in stimulating the nursing supply. It can be proud of its successful stewardship of nurse education funds and its good record in in-

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creasing the number of schools and the number of entering students and graduates. Even when admissions to associate and baccalaureate degree programs declined by 30% between 1983 and 1986, it was possible, using conventional supply-side wisdom and experience, for the Division of Nursing to answer political questions about the existence of a nursing shortage because graduates of RN programs reached an all-time high in 1985 when 82,075 young nurses entered the workplace (NLN, 1987).

However, close scrutiny of enrollments in nursing programs shows fewer first-year students (see Table 1). Since 1983, students in all RN programs have decreased more than 25%—from 250,000 in 1983 to fewer than 194,000 in 1986 (Landers, 1988). Preliminary data from the NLN (1987) indicate enrollments will be less than 180,000 for 1987.

But in early 1987, the traditional answer about the increase in the number of graduates failed to overcome the cries of the American Hospital Association (AHA, 1988), the largest employer of nurses, which reported an RN vacancy rate of 11.3% (which had more than doubled since 1983). In 1987, statistical reports from the federal government about the number of graduates from schools of nursing did not convince members of Congress who read not only the reports of nursing and hospital lobbies but also their local newspapers. Congressional staffs knew that while the 1987 AHA data reported regional differences, the shortage affected over 95% of urban and 74% of rural hospitals (AHA, 1988). The shortage was a public problem. The formation of the Davis Commission was prompted by the question of how to reconcile the increased number of graduates from RN programs and the RN participation in the work force in 1984 was 78.7% with the steady nurse vacancy rate reported (AHA, 1988). Hospitals reporting a severe (40%) or moderate (26%) RN shortage noted at least a 10% vacancy rate for licensed practical nurses. However, the overall vacancy rate for LPNs was 6.2% because 57% of the hospitals reported no vacancy (AHA, 1988).

It is not surprising that, given the data on the relative adequacy of the nurse supply, analysts of the 1980 shortage minimized the supply side of the equation and began to discuss demand.

Several demand theories have been advanced to explain the nursing shortage. The most common, and probably most accepted explanation, is the intensity of care thesis. This thesis espouses the belief that although fewer patients occupy hospital beds in the post-prospective care era, they require more medical and nursing care. A competitive posture in the health care system and public expectation requires investment in the expensive technology that enables sophisticated and complex diagnostic and therapeutic regimes. Because prospective payment legislation discourages the use of inpatient care, patients are admitted to hospitals only when treatments are imminent. As a result, they are sicker during their hospital experiences and are discharged before their conditions have stabilized. In 1987, 81% of hospitals reported a greater severity of illness of their patients than was reported in 1986 (AHA, 1988). Although hospital occupancy rates have declined in the post-prospective era, the demand for hospital-based acute care nurses is high because of the age of hospital patients, the complex nature of their illnesses, the use of high technology such as transplantation, and the shortening of the average length of stay. These factors support the intensity of care explanation—an inadequately defined concept that partially explains why hospitals employed 86 registered nurses per 100 patients in 1984 and 96 registered nurses per 100 patients in 1986 (Secretary's Commission on Nursing, 1988b).

> ***"The substitution of RNs for other nursing personnel created a further blurring of the work of professional nurses, contributed to the shortage, and influenced the AMA proposal to train registered care technicians."***

The changed financing in acute care hospitals has redirected care activities. People formerly admitted to inpatient settings for surgery are now day-surgery patients. Early discharge programs have increased demand for nurses in ambulatory care centers, homes, and extended care facilities. Patients in nursing homes and in home care programs are sicker because of early discharge from hospitals. Between 1981 and 1985 Medicare admissions to skilled nursing facilities increased by 23%. Registered nurse employment in Medicare-and Medicaid-certified nursing homes increased by 22% between 1981 and 1986. The average number of RNs per 100 beds increased from 5.2 to 5.7 in this period. From 1980 to 1987 Medicare home health visits made by registered nurses increased almost 60% (Secretary's Commission on Nursing, 1988b).

The expanded need for care in these settings is one factor in explaining the movement of nurses away from hospital work sites and the diminished nurse supply in acute-care hospitals. However, the changed care environments have also redirected the work of nurses in hospitals. Experienced nurses now work as discharge planners, case managers, and quality assurance experts.

Another factor in the demand equation is illustrated by the principle of substitution. Aiken and Mullinix (1987) argue that low wages make nurses attractive and versatile employees in hospitals. Nurses not only perform clinical care in hospitals, but also fill in for professional and nonprofessional workers. Any nurse who has worked in hospitals can define substitution and provide more than a few "war stories" about nurses doing the work of other health team members. Why, then, is substitution a factor in the current debate? There is some evidence that hospitals reduced their personnel budgets as an initial adjustment to prospective payment legislation. The work of nurses was expanded to encompass the work of furloughed employees who had performed clinical support functions, transportation services, and food services. The need for ancillary workers,

stimulated by high technology, the demands of labor unions, and new construction of hospital beds, have long been recognized. Their absence in the post-prospective health care system caused diminution of expected patient care services. Historically, nurses have been able to accommodate their own work loads while performing the tasks of others. The health care system of the eighties, however, is more complex. Nurses can no longer substitute for so many others.

In the eighties, the substitution of registered nurses for licensed practical nurses and aides was driven by clinical and economic forces. In the late seventies, professional support was given to the development of primary nursing practice and the recruitment of all RN staffs. This model was most popular in tertiary hospitals where RN staffs provided nursing care around the clock in critical care environments. After 1983, when levels of care increased in community and tertiary hospitals as the less sick were treated as outpatients and the still sick were sent home, all hospitals employed more registered nurses in all patient care units.

There was an economic as well as professional principle at work in the movement to an all-RN staff. The salary difference between licensed practical and registered nurses made professional nurses a bargain. Recent salary figures reported in the *American Journal of Nursing* (1988) indicate that there is approximately a $6,000 difference in mean starting salaries (RN, $20,964; LPN, $14,856) and a $9,000 spread in mean maximum salaries (RN, $29,088; LPN, $20,052). On average, a licensed practical nurse earns one-fourth less than a registered nurse, 75 cents on every dollar. In the height of the shortage, AHA data reveal that community hospitals faced with shortages hired registered nurses from agency pools and pressured permanent members of the RN nursing staff to work extra hours. Between 1983 and 1986, community hospitals reported a 25% decrease (56,000 full time equivalents) of licensed practical nurses and a 23% decrease (69,000 full time equivalents) of ancillary personnel. During this same period, these hospitals increased their employment of registered nurses by 5.5% (38,000 full time equivalents) (Secretary's Commission on Nursing, 1988b).

When the demand and price of registered nurses limited job opportunities for licensed practical nurses, enrollments fell in school of practical nursing.

The development of all RN staffs contributed to the use and demand for registered nurses. The substitution of RNs for other nursing personnel created a further blurring of the work of professional nurses, contributed to the shortage, and influenced the AMA proposal to train registered care technicians.

As the shortage of nurses continued into the fall of 1988, employers and insurers became uneasy because salary increases are always proposed during nursing shortages. *The American Journal of Nursing* (1988) reported that the so-called $40,000 solution is common in large cities such as Philadelphia. Boston's Faulkoner Hospital eliminated 77 middle management positions to underwrite a 17% raise for its staff nurses (new starting rate $26,051; new maximum salary $40,726). If registered nurses are paid significantly more than licensed practical nurses, all-RN staffs will increase hospital personnel budgets. Given the new salary scales, vice presidents for nursing and hospital administrators are less enthusiastic about all-RN staffing. When the salaries of registered nurses significantly outpace practical nurses, the RN/LPN ratio will shift.

The dramatic evolution of health care systems also contributes to demand for registered nurses. As has been noted, home care and ambulatory surgical centers have expanded greatly since 1983. More patients receive skilled care in long term settings. The need to manage care, coordinate the movement of patients through the system, and to monitor quality and cost has engaged nurses in these fields. Because enrollments and graduations have not kept pace with the developments in health care environments, new fields of practice compete with hospitals for a scarce work force.

Some insight can be given to the appeal of ambulatory and home care work sites by a closer glance at the AHA vacancy rate. Over 16% of the hospitals indicated that it took 60 or more days to recruit for "days only" positions and 53.7% found that recruitment for "nights only" positions required more than 90 days. Hospitals (46.9%) which required "rotation to all shifts" had the most difficulty filling positions; "day/evening" rotation had a shorter recruitment time than "day/night" or "evening/night" rotations. The largest number of vacancies was for "evening only" or "night only positions" (AHA, 1988), the so called hardship shifts.

The cost of nursing services affected demand in another way. For many years hospitals relied on students to perform hardship tasks. Later, new graduates worked weekends and shifts. These entry-level workers not only started at the first rung of the work ladder, they entered the labor market at the bottom of the pay scale. In periods of shortages, hospital administrators raise beginning salaries and offer bonuses to newly employed nurses. In times of severe shortage, however, raising entry-level salaries only redistributes the available work force. Some hospital administrators complain about the limited success of price wars carried out in local and national newspapers in attracting nurses to their cities and services. However, a review of salary scales reveals that raising entry-level salaries does not affect salary ranges. Wage compression is perhaps the most serious economic impediment to a career in nursing. In 1988, new graduates earned, on average, $7,000 less than nurses with 10 years of experience (Aiken & Mullinix, 1987). These salary data are not inflated by bullish responses to a diminishing market of new graduates. They represent the long-term accommodation of the industry to the school of nursing pipeline.

"Wage compression is perhaps the most serious economic impediment to a career in nursing."

The administrators who design salary, staffing, and benefit structures in acute-care hospitals (the

dominant standard setters in the health care system) presume that the nursing force is transient and inexperienced. Traditionally, the industry spent money on neophyte nurses who worked for their initial employers for several years. Hospitals showed little concern about what happened to staff nurses after a period of initial employment. Hospitals adjusted to

"Several demand theories have been advanced to explain the nursing shortage. The most common, and probably most accepted explanation, is the intensity of care thesis."

social forces that were described as marriage and child rearing; employment by another hospital; employment in other health settings; a return to school; movement along a career path to teaching, management or primary care; or a change of career. Because hospitals did not expect to retain more than a fraction of new recruits, their salary and benefit packages were oriented to new workers.

The Secretary's Commission on Nursing Interim Report (1988b) highlighted the inadequacy of this approach when women continue in the work force. The substitution of RNs for other nursing personnel created a further blurring of the work of professional nurses, contributed to the shortage, and influenced the AMA proposal to train registered care technicians. The Commission posited a relationship between poorly regarded career pathways and the lack of interest among college freshmen in the field of nursing.

The establishment of a link between the economic and professional rewards in the workplace and the presentation of nursing as a career is perhaps the most intriguing finding of the Davis Commission. As has been noted earlier, the expectation that earning power should increase with education and experience is not realized in nursing labor markets. The salary structures and fringe benefits do not recognize performance or tenure. There are no significant salary differentials for hardship shifts. Until recently, when some hospitals awarded bonuses to encourage retention based on the "frequent-flyer" programs model, the use of "the Baylor Plan" or some local accommodation to the rent-a-nurse agencies, illustrated creative scheduling arrangements in a woman's work force.

During the course of the Commission, it became apparent that administrators and the ANA bargaining units were recognizing that nurse retention is an industrial priority. It was also acknowledged that successful retention of nurses requires more than economic rewards. When the attention of employers was directed toward supply-oriented recruitment and the orientation of young graduates, little consideration was directed to the organization of the work environment or relationships in the work place. Authority, clinical decision making, staff involvement in the organization of professional practice, and relationships with physicians became important factors when the analysis focused attention on retention of registered nurses. Kramer's (1988b) second visit to the magnet hospitals—institutions recognized for their ability to attract and retain registered nurses—confirmed previous findings (Kramer, 1988a) that hospitals which recognized professional autonomy and respected the clinical competence of their nursing staffs did not experience shortages.

Any serious discussion about retention of staff nurses must concern itself with management. Nurse executives hold key information about staffing patterns, control the personal and work environment, influence the development and execution of budgets, and plan the ratio of nurses and nurse helpers. They can be significant forces in influencing the organizational climate and the work environment.

During the exploration of the work environment, the Commission requested a study of the influence of nurse managers with Boards of Trustees in acute-care hospitals (Kusserow, 1988). The rationale for this study centered on the importance of nurse executives in overcoming the nursing shortage. It also made several assumptions about power. Nurse executives with direct access to Boards of Directors could argue for more resources for nursing and address the importance of collegial relationships with the medical establishment. Positioning nurse executives among decision makers affirmed the importance of nursing within hospital organizations. Executives with access to power were more secure in their roles and more likely to experiment with new modes of practice and care delivery. It was argued that it would be foolish to recommend that staff nurses should exercise autonomy or clinical judgment if their superiors had limited power and lacked the ability to communicate with governing boards. To test the extent to which chief nursing officers participated in meetings of governing boards and prestigious board committees (finance, planning, executive, and joint conference), the Office of the Inspector General surveyed a representative sample of chief executive officers (CEOs) and chief nurse officers (CNOs) in 93 hospitals.

Although nurses in large hospitals (500+ beds) are more likely to engage in dialogues with governing boards, chief nurse officers, on average, were marginally involved in the governance of institutions. These findings support the belief that there is significant work to be done before staff nurses can participate in decision making.

The Commission (1988a) was so impressed with the importance of the work environment in addressing the nursing shortage that more than half of its 16 recommendations, listed in this text, address the reorganization of the work place.

- Health care delivery organizations should preserve the time of the nurse for the direct care of patients and families by providing adequate staffing levels for clinical and nonclinical support services.
- Health care delivery organizations should adopt innovative nurse staffing patterns that recognize and appropriately utilize the different levels of education, competence and experience among registered nurses, as well as between registered nurses, such as licensed practical nurses and

ancillary nursing personnel.

- The federal government should sponsor further research and encourage health care delivery organizations to develop and use automated information systems and other new labor-saving technologies as a means of better supporting nurses and other health professionals. Health care delivery organizations should work with researchers and manufacturers to ensure the applicability and cost-effectiveness of such information systems and technologies across all practice settings.
- Health care delivery organizations, nursing associations, and government and private health insurers should collaborate to develop and implement methods for costing, budgeting, reporting and tracking nursing resource utilization, both to enhance the management of nursing services and to assess their economic contribution to their employing organization.
- Policy-making, regulatory, and accreditation bodies that have an impact on health care at the national, state, and local levels should foster greater representation and active participation of the nursing profession in their decision-making activities.
- Employers of nurses should ensure active nurse participation in the governance, administration, and management of their organizations.

"The lack of a meaningful salary over a lifetime is a deterrent in vocational choice."

- Employers of nurses, as well as the medical profession, should recognize the appropriate clinical decision-making authority of nurses in relationship to other health care professionals, foster communication and collaboration among the health care team, and ensure that the appropriate provider delivers the necessary care. Close cooperation and mutual respect between nursing and medicine is essential.
- The nursing profession should take primary responsibility for providing immediate and sustained attention to the promotion of positive and accurate images of the profession and the work of nurses.
- The Department of Health and Human Services, private foundations, and employers of nurses should support and carry out research and demonstrations on the effects of nurse compensation, staffing patterns, decision-making authority, and career development on nurse supply and demand as well as health care cost and quality. Research should be sponsored on the relationship of health care financing and nursing practice.

This article began on a note of pessimism. Can one of the largest American industries adapt to address the needs of its work force? Can some of the private and public money paid for health services be redistributed so that physicians and institutional providers get less and nurses get more?

The analysis of the Commission suggests that the solution to the nursing shortage is not a quick-fix, but rather a sustained and systematic reexamination of the scope of nursing practice, the value of nursing to the health care system and the amount of money that individuals or groups are willing to pay for professional nursing services.

Table 1
*Annual Admission to Public and Private Basic RN Programs by Type of Program 1983–1984, 1984–1985, and 1985–1986**

Public and Private Nursing Programs	Number of Annual Admissions 1983–1984	1984–1985	1985–1986
All programs	123,824	118,224	100,791
Public	85,474	81,198	71,921
Private	38,350	37,026	28,870
Baccalaureate	39,400	39,573	34,310
Public	23,803	23,871	19,747
Private	15,597	15,702	14,563
Associate degree	66,576	63,776	56,635
Public	59,209	55,150	50,549
Private	7,367	8,626	6,086
Diploma	17,848	14,875	9,846
Public	2,462	2,177	1,625
Private	15,386	12,698	8,221

*Source: Rosenfeld, P. (1987). *Nursing student census with policy implications*. Pub. No. 19-2202, New York: NLN, p. 22.

Excludes American Samoa, Guam, Puerto Rico, and the Virgin Islands.

References

Aiken, L. H., & Mullinix, C. F. (1987). The nurse shortage: Myth or reality? *The New England Journal of Medicine, 317*(10), 641–646.

American Hospital Association. (1988). *Report of the 1987 nursing hospital personnel survey*. Chicago: American Hospital Association.

American Hospital Association and American Organization of Nurse Executives. (1987). *Report of the 1986 hospital nursing supply survey*. Chicago: American Hospital Association.

Green, K. (1987). The educational pipeline in nursing. *Journal of Professional Nursing, 3*(4), 247–257.

Institute of Medicine. National Research Council. (1983). *Nursing and nursing education*. Washington, DC: National Academy of Sciences Press.

Kramer, M., & Schmalenberg, C. (1988a). Magnet hospitals: Part I. *Journal Nursing Administration, 18*(1), 13–24.

Kramer, M., & Schmalenberg, C. (1988b). Magnet hospitals: Part II. *Journal Nursing Administration, 18*(2), 11–19.

Kusserow, R. P. (1988, October). *Nurse participation in hospital decision making. Potential impact on the nursing shortage*. (No. 0A1-03-88-01120). Washington, DC: Department of Health and Human Services, Office of the Inspector General. Office of Analysis and Inspection.

Landers, R. K. (1988). What is causing the nurse shortage? *Editorial Research Reports* (pp. 158–166). Washington, DC: Congressional Quarterly, Inc.

National League for Nursing. (1963). *The Surgeon General's Report and Collegiate Nursing Education*. (No. 15–1092). New York: National League for Nursing. Department of Baccalaureate and Higher Degree Programs.

Nurses again lost some economic ground in '87. (1988). *American Journal of Nursing, 88*(1), 112, 114–116.

Rosenfeld, P. (1987). *Nursing student census with policy implications*. (Pub. No. 19–2202, p. 22). New York: National League for Nursing.

Secretary's Commission on Nursing. (1988a). *Final Report. Volume 1*.

Secretary's Commission on Nursing. (1988b). *Interim Report*.

Winslow, C. E. A. (Ed.). (1923). *Nursing and nursing education in the United States*, New York: The MacMillan Co.